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Observations and Deductions on the Matter of Epidemic Pneumonia

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ONE might maintain with some degree of justice that pneumonia is such a well-worn subject that a consideration of it at this late date would be little likely to add to our knowledge. Yet he would be bold to the degree of dogmatism who would maintain that we have attained finality in any subject of medical interest. I read only the other day in an article by a medical man of repute, under date of 1916, this statement, "The bacteriology of influenza is fully established." One has only to peruse the many articles on this disease, based on the clinical and laboratory study of the recent epidemic, to realize that, on the contrary, the whole subject is in a muddle, and that there is no unanimity of opinion as to the specific character of the infection. I may, therefore, be excused for dabbling in this puddle, muddled for the time rather than clarified by the exertions of those upon its margin, but which, in all likelihood after, the opacities have settled, will give place to the clear well of truth.

By way of clearing the ground, I may, at the outset perhaps, be permitted to recall certain commonplaces of knowledge. There is the topographical classification of pneumonias, into *lobar* and *lobular*. Of the first, the so-called acute "croupous" pneumonia is taken as the type; of the second, broncho-pneumonia. Then, again, from the etiological standpoint, we recognize (1) Primary pneumonias, and (2) Secondary pneumonias, which may be further divided into *complicating*

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and *terminal*. The complicating pneumonias are those which occur in the course of other diseases, usually infectious, such as typhoid fever, scarlatina, measles, small-pox, rheumatic fever, diphtheria, cerebro-spinal fever, whooping-cough, and rickets. The terminal pneumonias are those which usher in the final scene in those who are the subjects of chronic disease, tuberculosis, Bright's disease, diabetes, carcinoma, and the like.

These conceptions are helpful, at least on the clinical side, but for the pathologist and bacteriologist the problem is by no means so simple. All grades of inflammation may exist, from a simple desquamative catarrh to the most intense suppurative process, or even gangrene. The various stages of a pneumonia, again, may be irregularly manifested. Or, a particular microorganism may fail to produce the regulation pathological picture, but give rise to something quite different. Again, bacteria of widely-differing character will frequently set up inflammatory processes difficult or even impossible to distinguish, one from the other. Finally, one or many bacterial species may be at work. The combinations and permutations are, therefore, endless, and pneumonia might almost be called the despair of the scientific medical worker. The newer bacteriological technique, whereby closely related forms of bacteria can be differentiated, together with the numerous studies in immunity, are, however, gradually bringing order out of chaos. We now are realizing that pneumonia is not a disease, but rather a symptom-complex, the anatomical features of which are protean, the specific causes many. Moreover, several specific causes may be associated in one and the same case.

It has been taught from time immemorial that chilling of the body and fatigue are the most important determining factors in the production of pneumonia, and it is within the professional lifetime of all of us that this view has given place to the doctrine of specific infection. Now that this point is settled, questions such as the modes of infection and of transmission loom into importance and can be scientifically dealt with.

Not a few still hold the view that infective agents can give rise to inflammation of the bronchi and lungs, tuberculosis and pneumonia, for example, through inhalation. Careful investigation of this matter goes to show that this idea is incorrect, with the possible exception of "aspiration" pneumonia, which occasionally supervenes on anaesthesia, especially in connection with operations on the buccal cavity. Aufrecht, years ago, demonstrated the physical impossibility of foreign particles, such as dust or soot, being carried into the recesses of the lung in the ordinary process of respiration. The tortuous course of the respiratory tube, the ciliated epithelium, the moisture on the mucous surface, together with the reflex cough excited by surface irritation, tending to eliminate the

offender, are usually sufficient to prevent direct infection of the lung. The available evidence goes to show that microorganisms pass into the body from the surface of the nasopharynx, being picked up by leucocytes, and being then carried along the lymphatics to the nearest regional lymph-nodes, thence passing down the neck to the peribronchial nodes. There, bacteria may remain latent for long periods, even years.

It is not generally known, but experiments have proved, that micro-organisms introduced into the conjunctival sac make their way to the nasopharynx in a very few minutes. Thus, an unsuspected point of entrance for infection is commonly available.

Some germs, if the dose be large enough, or frequently enough repeated gain access to the blood, and speedily reach the lung. Then, given sufficient virulence, or a weakened constitutional resistance, or, perhaps, a local tissue susceptibility, pneumonia follows. That epidemics of pneumonia may occur was well known to Laennec, Grisolle, and Jurgensen, in the early days, and gave support to the doctrine of contagion. Given a sufficient degree of virulence of the germs, and a sufficient degree of concentration, their occurrence need surprise nobody.

Outbreaks of primary, lobar, or so-called "croupous" pneumonia rarely attain epidemic proportions in this country, being usually limited to the development of several, after the initial case, in the same dwelling (household epidemics), or to an inordinate run of cases in institutions, but spread out over months. Epidemics of any considerable extent are of the lobular or broncho pneumonic type, and come in the wake of infectious diseases, such as measles and influenza.

In late years the most extensive outbreak of pneumonia was that which occurred in connection with the recent epidemic of so-called Spanish Influenza, which, after devastating Spain, Portugal, France, Germany, and England, finally reached America, appearing in Nova Scotia towards the end of last September. This epidemic differs from previous ones designated influenza in that it attacked by preference the young and robust: was complicated by pneumonia in a high percentage of cases; frequently assumed the appearance of an intense septicæmia; and was attended by great mortality. Various studies of this epidemic have lately become available, and we are in a position to make some important deductions.

With regard to pneumonia the following figures are of interest. In the various Military Districts of Canada 11,496 cases of "influenza" were reported. 19.2% developed bronchopneumonia. At Camp Jackson, Columbia, S.C., U.S.C., Chickering and Park record 8,100 cases of influenza, with a percentage of 17.28 of pneumonias supervening. At Camp Grant, Ill., Hirsch and McKinney found that among 9,037

admissions for influenza, 26% developed bronchopneumonia. I am satisfied that these figures, high as they are, do not tell the whole story. It seems reasonable to suppose that many cases of so-called influenza, notably those with marked respiratory disorder, such as bronchitis, might be really cases of bronchopneumonia which resolve before the physical examination is conclusive. Many, also, might be so mild that evidences of bronchopneumonia might be overlooked, especially in the stress of handling an extensive epidemic. We all know the difficulties in the way of diagnosing with certainty a condition so elusive as bronchopneumonia. Inasmuch as the consolidation is at first patchy, and the areas may be of even minute size, dulness of the percussion note is either non-existent, or is masked by the hyperresonance of the accompanying compensatory emphysema. The breath sounds, also, may be overwhelmed by bronchitic dry rales. When the patches become confluent and the case approximates more closely to the lobar type, diagnosis is easy, but many cases never reach this stage. Personally, the signs upon which I lay most stress, in the case of a febrile disease with acute respiratory distress, are hyperresonance, a certain harshness of the breathing in various areas, and a tendency to bronchophony in these areas. Fine crepitations, in spots, would clinch the matter, but are not always found. Taking such criteria, and considering the haste with which many examinations had to be made by the overworked physician, it is altogether likely that the percentages of bronchopneumonia ensuing in influenza are greatly understated. To support this contention, I might cite the work of Diemer at Camp Lewis, American Lake, Wash., U.S.A., who radiographed some 7,000 influenza patients, all suffering from symptoms of "cold", but not diagnosed as pneumonic. He was able to demonstrate bronchopneumonia in about 2,200 cases, in many instances before clinical findings were definite, and even where clinical examinations was entirely negative, except for bronchitis.

In regard to the bacteriology of the cases the findings vary greatly in different localities. In Military District No. 2 B. Influenza was found in 94% of cases, alone in 15%. In one district streptococcus predominated; in another pneumococcus. In one camp in the United States the staphylococcus was most often found. All reports, however, agree in this, that the infection is almost always mixed. This fact, and the further fact that B. Influenza is more often absent than not; and, again, that all the organisms incriminated have been often found in the healthy nasopharynx, raises a doubt as to the propriety of the term "Influenza", if by it we mean an infection due to B. Influenza of Pleiffer, and, indeed, whether any of the microorganisms found ought to be regarded as the primary and specific cause of the disease called Influenza. In fact, not a few bacteriologists held that these bacterial

forms are merely secondary invaders, possibly symbiotically aggravating the condition, inviting complications, and increasing mortality, but not the primary etiological factors. And in this connection I should refer to some recent work of Sir John Rose Bradford, and Capts. Bashford and Wilson, who record the discovery of a hitherto undescribed micro-organism, a filter passer, which grows characteristically, can be demonstrated in the sputum, where it assumes a pathognomonic arrangement, and which, inoculated into experimental animals can reproduce the pulmonary and other features found in human influenza. This organism is commonly found in the blood. The disease, therefore, in the light of these findings is a specific septicæmia, with a local manifestation in the lung, the virus exerting itself in a peculiar and intense manner on the walls of the blood vessels. These observations have not been confirmed, and perhaps may not be till the next epidemic, but would seem to be accurate. At least they open up a new field of research and are in harmony with the later opinions on the etiology of the affection.

Such a conception explains, as none other does, the protean character of influenza. It explains the fulminating form, in which the patient dies in a few hours with a profound toxæmia; with the most intense œdema and congestion of the lungs, but without true consolidation; it regards the pneumonic process as primarily due to the new organism, but assisted by and modified by the other bacterial forms we have referred to. It explains the peculiar degeneration of the heart and kidneys, the haemorrhages into the muscles; the curious lividity; the intense and prolonged prostration. The characteristic virus is a special and unusual one.

It may be the lot of the medical officer of health at any time to have to deal with the prevention and limitation of epidemics of pneumonia. The lines which his efforts should follow may be inferred from the foregoing remarks. The measures to be adopted fall into two categories, general and particular. There is a somewhat trite saying current among us, "In time of peace prepare for war". In view of the fact that any or all of the microorganisms associated in various degrees of casual relationship with epidemic pneumonia are common inhabitants of the nasopharynx, not only in diseased conditions of that cavity, but in healthy persons also, it is clear that any abnormalities in throat, nose, or teeth should be corrected, not only in the adult, but in the young. Here, the services of the school doctor or nurse are of great value. Adenoids and diseased tonsils should be removed; hypertrophy of the nasal mucosa corrected; catarrhal conditions dealt with promptly; and the teeth frequently inspected and treated when necessary. The use of the tooth-brush should be inculcated upon all. Precepts on the evil consequences of spitting in public places, and on the danger of exchang-

ing handkerchiefs, pencils, chewing-gum, practices common among the young, and the inadvisability of putting anything into the mouth but food and drink, are always in order.

Then as it has been found that, given the actual presence of the infective agent in the body, cases of pneumonia become more frequent and more virulent under conditions of overcrowding, imperfect lighting, dusty surroundings, and fatigue, the virtues of fresh air, abundance of sunlight, sufficient rest, and general cleanliness should be insisted on, in season and out of season.

Then comes the problem of the "carrier". Every case of pneumonia is a carrier for a variable period during and, perhaps, after, convalescence; every attendant on a case of pneumonia is a potential carrier. Observations made at the Rockefeller Hospital upon normal individuals have proved that the pneumococcus so often present in the mouth belongs to type IV, the most ill-defined and least pathogenic of the forms usually met with in this country. Stillman (*Journ. of Exper. Med.*, 1917, 26, page 513) found that the pneumococcus present in the dust of rooms in which cases of pneumonia had not occurred belonged to the same type that occurs in the normal mouth. He brought out the interesting point, also, that pneumococci are more common in the dust of rooms in which cases of pneumonia (types I and II) have been tended than in other rooms. It has also been shown conclusively that carriers harbour in their mouths the same types of pneumococci as were present in the cases of pneumonia with which they had been in contact.

The available evidence, therefore, goes to show that pneumonia is communicated for the most part through the agency of the carrier. Pneumonia, therefore, even the sporadic form, should be regarded as a dangerous infectious disease and dealt with as such. Unnecessary visitors should be interdicted. Care should be taken to avoid mixing the utensils of the sick room with those of the rest of the household, and both utensils and bedding should be put at once into boiling water when dispensed with. The patient's mouth and nose must be kept scrupulously clean, by the use of suitable disinfectant sprays or washes of mild character. This not only lessens the dose of the infective material which the patient is receiving daily, but lessens the danger for others. Of the newer disinfectant agents recommended, as being particularly deadly for the pneumococcus, are ethylhydrocuprein and other cinchona derivatives (Morgenroth and Levy, Wright, Moore, Kolmer and Steinfield). The last-mentioned experimenters recommend mouth washes of ethylhydrocuprein hydrochloride or quinine bisulphate, compounded with liquor thymolis (1 to 10), so as to make a solution of the drug of 1 to 10,000 strength (liquor thymolis is made up at the Philadelphia Polyclinic as follows: benzoic acid, 64 grains; boracic

acid, 128 grains; thymol and menthol aa. 16 grains; oil of eucalyptus, oil of wintergreen, and oil monarda, of each 4 drops; alcohol and glycerine, of each 4 ounces; water to make 16 ounces).

The length of time during which an individual, patient or contact, may be infective varies within wide limits. Stillman, studying 84 persons who had been in contact with pneumonia cases, found that the carriers harboured the germ for from seven to eighty-five days. Dochoz and Avery record that a patient recovered from pneumonia was infective for as long as ninety days. It would hardly be feasible to quarantine patients and contacts for as long as three months, but the frequent use of the antiseptic wash or spray would lessen the danger of spreading the disease very materially.

Experience has shown that in times of epidemic not only does the case incidence rapidly reach an acme, but also the virulence of the disease is coincidentally increased. The early strangulation of an epidemic, therefore, is of the greatest importance. One may profitably inquire here as to the efficacy of preventive inoculation. Vaccines are in some cases of extreme value in preventing infectious disease, notably in small-pox, typhoid, paratyphoid, dysentery, cholera, and plague. To be effective, the vaccine should be homologous, that is, composed of the same microorganism, or of its products, that is causing the infection. Preferably, it should be autogenous. Even when all due precautions are taken, the scope of vaccines for prophylaxis is somewhat limited. In the case of epidemic pneumonias the problem is quite difficult. As I have indicated a great variety of organisms are at work, some of great pathogenic power, others less virulent. Some play a principal role; others may be merely present as "accomplices", as the French term them. Still others may be associated simply as saprophytes, but without any special importance. Our information at present is not sufficient to permit us to appraise the importance of each. In some instances, it may be found that the appropriate vaccine is ineffective. In any case a multiple vaccine would probably be required. Now, as it would appear that the microorganisms concerned are not always the same, nor are they always associated in the same groupings, either in different epidemics, or in different localities in the same epidemic, it is obvious that a vaccine, no matter how scientifically compounded, cannot be expected to meet completely all indications. At the present time the best we can do is to pick out the germs that are most frequently found and prepare a vaccine from them. These are pneumococcus and streptococcus, half brothers in iniquity, as in bacteriological peculiarities. Fortunately we now possess experimental and clinical evidence that pneumococcus vaccines are of considerable value for immunizing purposes. The evidence on the matter of streptococcus vaccines is less

convincing, but at least in experimental animals it is possible to bring about active immunity by the injection of streptococci, dead, attenuated, and living.

Perhaps the first attempt on a large scale to bring about prophylaxis in pneumonia was that of Wright, who, working in Africa, obtained a reduction of 50% in the incidence of the disease among the natives working in the mines. His vaccine was made up with saline and was given in two doses of 1,000,000,000 each. This was, however, before the days of the typed pneumococcus, so that his results are sufficiently striking. Soon after, F. S. Lister, with a vaccine composed of the three types of pneumococcus responsible for 69% of the cases of pneumonia among the natives of the Transvaal, obtained extremely encouraging results also.

In America, early in 1918, Cecil and Austin published the results of prophylactic vaccination of 12,519 men at Camp Upton with pneumococci of types I, II, and III. No cases of pneumonia due to these types occurred among those vaccinated, and, moreover, cases of pneumonia due to type IV and to streptococci were much fewer than in the uninoculated.

At Camp Wheeler, Cecil and Vaughan report the results in the case of 13,460 who received a vaccine containing types I, II, and III. Among 13,343 vaccinated the incidence of pneumonia was 26.1 per 1,000, and in 3,378 unvaccinated was 68.3 per 1,000. As immunity was not found to begin to occur until the eight days, if the cases developing pneumonia within the first week after injection be deducted the results are still more striking.

I have indicated above the multifarious nature of the germs present in influenza and the complicating pneumonias of influenza, and have pointed out the difficulty of establishing each species in its proper etiological relationship. The pathogenicity of the various forms can in a measure be gauged by their power to produce immune bodies in the serum of the individual infected. Once this information is obtained it affords us a substantial basis on which to establish our vaccine prophylaxis. A beginning in this direction has been made by Kolmer, Trix, and Yagle (*Journ. of Infect. Diseases*, vol. 24, No. 6, page 583). In a very valuable paper these investigators state that the sera of 45-50% of persons suffering from influenza yielded complement fixation with the polyvalent antigen of B. Influenza. Also, there was a slight increase in the amount of opsonins and agglutinins in these cases.

Complement fixation occurred with the sera of 38% of persons ill with influenza, using a polyvalent antigen of haemolytic streptococci. Opsonins were slightly increased during the first week of influenza, but decreased with the onset of pneumonia. Agglutinins apparently were

not increased. About 38% of sera from cases of influenza gave a positive complement fixation against a polyvalent antigen of *n. catarrhalis*. There was in this instance no increase in opsonins and agglutinins.

The sera of persons suffering from influenza, in whom *staphylococcus aureus* and *pseudodiphtheria bacilli* were found, in general gave no complement fixation with antigens prepared from these germs, nor were opsonins and agglutinins increased.

Thus it would seem that, in the epidemic studied by them at least, the most important roles in inducing infection were played by *B. influenza*, *streptococcus haemolyticus*, and *micrococcus catarrhalis*, and in the order given. This work is of great importance and it is to be hoped that further studies along these lines will be forthcoming. It should be stated that Kolmer, Trist, and Yagle did not apply the parallel series of test to the pneumococcus, doubtless, though they do not say so, because the data respecting this germ are fairly well established.

So far as our information goes, at this date, a vaccine composed of pneumococci (of the various types), *b. influenza*, *streptococci* (haemolytic), and *micrococcus catarrhalis* would, with much show of reason, be likely to prove efficacious for the prevention of these epidemic pneumonias and the amelioration of the infection now termed influenza. As a matter of fact, a vaccine of this order has been tested out, with this difference, that the *n. catarrhalis* was left out. Minaker and Irvine (*Journ. Amer. Med. Assoc.*, vol. LXXII, No. 12, page 847) detail their work in this direction. In a population of 1,233,782 uninoculated persons there were 43,671 cases of influenza, a percentage of 3.54. The mortality was 8.5%. In 6,400 inoculated there was a case incidence of 111, a percentage of 1.73, with a mortality of 1.8%.

In view of the foregoing studies, I would sum up the duties of medical men, and particularly Medical Health Officers, in the face of epidemics or threatened epidemics of pneumonia, such as follows:—To

- (1) Instruct people generally to live "the simple life", and to keep in the open air as much as possible.
- (2) Prevent the congregation of people in assemblies within doors.
- (3) Advise the inoculation of all unattacked persons with an approved vaccine. This, in my judgment, for the present at least, should contain pneumococci, types I, II, III, *b. influenza*, *staphylococcus aureus*, *streptococcus haemolyticus*, *micrococcus catarrhalis*.
- (4) Recognize early and report cases to proper authority.
- (5) Segregate all suspects until such time as diagnosis is properly established.
- (6) Order strict quarantine of all cases for, say, the first week. If, in spite of this, the disease becomes epidemic, it is not possible to enforce such a measure.

(7) Isolate actual cases in hospitals, extemporized hospitals, or in tents, in the face of extensive outbreaks. The spread of infection is much more rapid when patients are retained in their homes.

(8) Advise the use of suitable sprays, mouth washes, and gargles by patients, suspects, and contacts, not forgetting disinfection of the conjunctival sac.

(9) Recommend the use of masks by doctors, nurses, and attendants, while in the sick room. These masks should be large enough to cover the whole face, and should be provided with windows for the eyes.

(10) Apply the open-air treatment in fine weather; avoid all over-crowding of special hospitals.

(11) Remove convalescing patients from the hospitals to other buildings.

(12) Segregate convalescents for two weeks, using proper sprays for nose and throat.

(13) Publish in the daily press the precautions advised and the reasons therefor.

Statutory Practice

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THE Great War with its manifold revelations exposed to the noon-day glare many national defects; the recent epidemic of influenza came a close second, yea, came first, as far as the profession is concerned in exposing the unpreparedness of the army of defence, not only in our own Province, but over the North American Continent.

Even as in the early advance into Belgium of the Hunnish horde in the summer of 1914, and the relentless "driving in" of the heroic Belgian army; so we found ourselves driven to bay by the sudden advance of the legions of Pfeifer, supported in many instances by the forces of Fränkel.

Had it not been for the permanent general staff and our respected Generalissimo, chaos would almost have reigned, as the pressure became worse and the general practitioners became overworked—not a few, alas, succumbing to the disease, martyrs at their posts of duty! And right here it might be opportune to suggest some memorial to the brave members of our profession who virtually "died in harness".

Now notwithstanding the indefatigable and intelligent manner in which the Provincial Health Officer has acted in the face of such an epidemic, it is quite patent to all, that owing to various causes, he has not had the support in carrying out in detail the provisions of the Health Act, as well as in many ways, not at all within the scope of laws and acts.

As an example, a so-called "flying squad" of nurses, and physicians as well, if the latter could be obtained, should, if available, have been despatched to the different parts of the Province, where the enemy was rapidly gaining a foothold. Remember, I quite realize the scarcity of physicians and nurses last autumn and winter owing to overseas requirements, yet the fact remains that were they available, this would be the correct procedure, *viz.*, the strengthening of the local force by a contingent of nurses when the outbreak was rapidly augmenting.

We are amending and improving our health laws from time to time, but it seems as if we were preparing to "lock the stable after the steed had been stolen." It is as if the ablest strategist and tactitian during the Great War had attempted to stay the oncoming enemy by a barrage from cannon that had done duty at the siege of Louisbourg.

Without calling in question any of the provisions of the amended Health Act, a few observations from the rank and file of the profession might not be out of place.

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(1) While public assemblages such as churches and schools could be closed, the travel by train, street car and steamboat was not, or could not be wholly eliminated. It has been fairly well demonstrated that the quarantine public and private has been more or less of a failure. It has been shown again and again that children attending school have been exempt, whilst those kept at home have been seized by the disease. In fact, in the villages and towns, the children seemed safer in schools than roaming the streets or playing in groups.

(2) Quarantine injunctions became meaningless at the outset, because in 90% of the placarding it was ineffectual on the principle that if a farmer coops up his chickens he must forsooth feed and water them several times daily.

We all know the "red tape" to be followed if small-pox invades our municipalities, and the endless vexations in having a watchman or constable supervise the wants of the quarantined ones; how, if such an official is conceded as a necessary evil, and he is permitted to draw a few dollars in this way, then in sequence, the grocer who supplies the "necessities" as well, as the long suffering doctor, is pitilessly sacrificed before the august finance committee.

It may have been that in days past certain brethren may have injudiciously padded their wallets from the municipal funds, yet we do not all come under the black flag of the "skull and crossbones", and many a weary mile has been covered and a very moderate account rendered to the Council to receive the desserts that it ill deserved.

I submit, and I feel that 99% of our councillors will agree with me, that medical accounts which should include all quarantine bills, should be "checked off" in the Provincial Health Office, with an auditor if you will, from the municipality where the work was contracted.

To recapitulate, then, if a complete quarantine was inaugurated, with watchmen on the doors, with food being supplied at the country's expense, then, in the face of such an epidemic, it were useless to quarantine for in reality every second family would be flying the yellow emblem.

Hence, because there is not that fine sense of reciprocal interchange between the Provincial Health Office and the Municipal Office due to an antiquated system that is hard to uproot, the *Flu* quarantine became ineffectual. May we pray that in the "process of the suns", the Health Office at Halifax may continue to direct our efforts, as well as adjust the accounts of all concerned in carrying out the provisions of the Health Act.

Owing to shamelessly inadequate nursing help we found that to put on a rigid quarantine the helpless victims would assuredly perish, e.g., a family all stricken simultaneously. We have seen instances where, were it not for the unselfish and noble attempts at relief by a

near neighbour, the cases would have succumbed. This was unavoidable and in many cases the kindly neighbour was soon stricken.

This, it would seem, could have been controlled and the spread of the epidemic greatly lessened by the appointment of a "sanitary patrol", composed of one or more for a village or countryside, whose duty it would be to see that none entered or left infected houses; see that ventilation was observed, and in general see that a *real* quarantine was respected.

If the Health Office at Halifax had the powers they should be vested in, and the immediate municipal response to make the same effective, a *wire* from the Provincial Health Office should have an official appointed in a few hours, and for that matter have complete powers to inaugurate quarantines direct from headquarters. And again it is confidently stated that if federal authority in the matter of the ramifications of the Health Act is concerned were given to the Provincial Health Office our fine type of councillors would not demur, but on the contrary be very pleased to hand over a troublesome phase of municipal business now conducted by them.

As it is now, to accomplish a quarantine follow the procedure: (1) Search the minutes of the Council, or its list of officers, to pick out the "local board" for the district. A case in point would be, say, five farmers living at all distances in this district, some, perhaps, without telephones, or absent from their homes and no way of notifying them; likewise picture if you will the discomfiture of the councillor who is automatically chairman, as he tries to parry the doctor's arguments as to the necessity of placing a patrol or constable in a village where twenty-five cases are rapidly becoming fifty and so on. Has he the power? he argues. What will his constituents think? Mr. So-and-So is well able to pay for his sustenance and he shall receive no help from the country, whilst Mr. So-and-So, if not too ill, vows that he will have the councillor's scalp and so on.

These, brethren, are some of the arguments to be met by a physician in his combat of the Flu and kindred epidemics. Again, if paupers live in an infected district, well we all have had that bitter experience and it is just as bitter for the councillor who is endeavouring to restrain and limit accounts affecting his district.

The remedy for all this may rest with the Divisional Superintendents, the District Nurse, etc., but even so we have felt that orders should come direct from Halifax relative to quarantine—in a word, relieve our County Councils of such matters altogether, and make such accounts chargeable to the municipality in the same way as commitments are now paid or a coroner's fees is liquidated. Just so long as a wrangle exists between the physicians and the council, just so long and just so

generally will epidemics spread. It is very false economy to estimate the cost of fighting such an epidemic as the Flu. The motto should be "Stamp it out and reckon the cost afterward".

The above represents some thoughts that recurred again and again as we have been brought face to face with disease and its various results in this Province.

And now, we would be inclined to ask, why are measles, pertussis, phlegmononstonsillitis, and the parasitic skin diseases as scabies and impetigo contagios (commonly called "swinepox") not segregated?

The latter is extremely contagious, and all practitioners have seen it work havoc with the tender cutaneous structures of children and even adults, the face becoming further and further auto-infected, until a mass of pustules extend around the mouth and chin and invade the cheeks as well.

Take the above list, and, compared with mild smallpox, which is quarantinable by statute, there is not much to choose between them.

What, may I ask, is more grave in effects than measles and whooping-cough? It may not be necessary to quarantine the whole family away from the public but let the infected member be handled as if he or she had contracted variola, and this difference only made, that the victim be kept studiously to one apartment and not have the whole range of the household.

It is shameful to see the ravages of measles and whooping-cough upon a family of small children, which, if a process of segregation had been enforced, might have saved promising lives. For the sequelæ of the exanthers are frequently deadly, and I have had cases in my own experience where the temperature of measles has continued into phthisis and the racking pulmonary pertussis has been the binder that ignited the T.B. in an inherited soil.

It may be argued that if quarantine were to embrace these diseases, an endless chain of quarantining would ensue. I would prefer segregation in these cases.

The ideal method would be the early reporting of a suspicious rash or a spastic cough; upon the physician's diagnosis being confirmatory much suffering and possible death could be avoided if the child were removed to a room as far from the family quarters as possible until danger was past.

It is a common experience also to find that diphtheria *e.g.* has become almost epidemic in a trice due to a family concealing a sore throat or wilfully making light of the same. A penalty enforced for this kind of thing would prove salutary.

The Nineteenth Annual Report of the Executive Council of the Canadian Association for the Prevention of Tuberculosis

GEO. D. PORTER, M.B., *Secretary*

IT is encouraging to note that in this our Nineteenth Annual Meeting we are again able to report progress. In the different centres such as Sanatoria, special Tuberculosis Hospitals, Dispensaries and Laboratories there is a steady growth in the amount of work being done for the care of the tuberculous and in the efforts made towards its prevention. More accommodation for the tuberculous, more home care, more widespread efforts on the part of Provincial and Municipal health authorities in the same direction and in the matter of education of the public can be reported.

Of special interest is the new Laval Hospital for the tuberculous recently opened at St. Foye, Quebec. This splendid institution, now caring for about 100 patients, cost some \$250,000. Of this amount \$150,000 was raised by the Knights of Columbus. The Province added \$25,000, the municipality about the same, and the remainder was raised by private subscriptions. This is still another notable accomplishment for private initiative in the doing of which local public opinion must have been largely educated on the tuberculosis problem. "An educated public opinion", as pointed out by Livingston Farrand, "much needed by health officials of the country in order to carry through measures which they know should be enforced and administered". Much of the credit for this enterprise is due to Dr. Rousseau of Quebec, who has so long been identified with this movement and who has been untiring in his efforts towards securing some adequate provision for the tuberculous in Quebec.

Another example of private initiative, so noteworthy in the tuberculosis movement in Canada, is the Rotary Institute for Diseases of the Chest. This dispensary just opened in Vancouver is the result of a body of public spirited citizens, the Rotary Club of that city taking hold of an important problem in their own city in a way which should prove most useful for controlling a menacing disease in their midst. This makes seventeen dispensaries now in Canada, and according to the report of the sub-committee on tuberculosis appointed by the conference

representing the Allied Red Cross Societies under the Presidency of Sir Robert Philip, "The centre and pivot for the control of tuberculosis is the dispensary." Quoting further from this report, as showing lines of development which are also being followed here: "With this must be closely linked sanatoria hospitals or homes for advanced cases, open air schools, and farm colonies. Particular importance was urged on attention to such vital matters as the care of children, the problems of housing, nutrition and alcoholism; the institution of appropriate measures to prevent the transmission of tuberculosis through infected milk; open air schools for the accommodation of children already infected by or suspected of tuberculosis; close co-operation between the several institutional factors—dispensaries, hospitals, and sanatoria—and the more extended development of skilled social service under medical care."

Among the movements not yet completed but of special interest are the large Provincial Institutions already begun in Alberta, the one in Montreal for the establishment of a hospital for curable cases in that city, the special babies' ward at the I.O.D.E. Preventorium in Toronto and the I.O.D.E. Preventorium at the Provincial Sanatorium in Saskatchewan. The many improvements and additions, notably those to the Provincial Sanatorium in Nova Scotia, will be noted in the various local reports.

Measures recently taken by the Department of Agriculture to provide against contaminated milk are most important. The former regulations have been amended so that any town or city may apply for Government aid and the compensation has been raised for those losing cattle reacting to the tuberculosis test. The importance of this work to the health of the community, especially to the welfare of the children, cannot be over-estimated. Since this work was begun there have been over seven hundred diseased cows removed from the dairies supplying four cities and towns.

During the year our Executive Council passed a resolution "strongly endorsing the suggestion for laboratory arrangements being made whereby serological tests for the tuberculous or suspect tuberculous patients can be carried out at different University and Provincial Board of Health Laboratories in Canada", and another expressing "Approval of the offer of the Connaught Laboratories, University of Toronto, to assist in this work". Since then this forward step in the extension of research on pulmonary diseases, and one which promises some aid in tuberculosis, had been initiated by the Department of Soldiers Civil Re-Establishment with the assistance of the research department of the University of Toronto. They are beginning with the complement fixation and other modern laboratory tests on the cases, both military and

civil, appearing at the General Chest Clinic of the Toronto General Hospital. Dr. Alfred Caulfield is at present the physician in charge of this work. It is hoped and intended that the number of these clinics should be enlarged so that outlying sanatoriums can also take advantage of them.

Another resolution forwarded from the National Sanatorium Association was passed by our Executive. This was to the effect that "owing to the existing great need for more nurses with special instruction and experience in the care of tuberculous patients it would seem to be advisable that all existing training schools in Canada should undertake, by affiliation with hospitals and sanatoria for tuberculosis or otherwise to give to their nurses in training at least a two months' intensive course to fit them for the adequate care of such cases.

A forward step in the treatment of tuberculosis has been made, we believe, in the increased attention now being paid to vocational training among patients. This was started in 1916 and has been developed steadily under the Department of Soldiers Civil Re-Establishment in Sanatoria where there are at present 1,660 patients besides 147 outpatients under their care.

The patients are divided into the following:

Class A.—Bed cases suffering from the disease in acute stage and who remain in bed until their temperature is practically normal.

Class B.—Porch cases who go to meals three times a day and rest in chairs in the fresh air the remainder of the day.

Class C.—Exercise cases who commence by taking a fifteen minutes' walking exercise daily, gradually increasing to two hours' walk each morning and a similar walk in the afternoon.

Patients in Class A are sometimes able to undertake light work, such as lace-making, drawing, weaving, etc.

Patients in Class B are able to do more of the same kind of work as that assigned to Class A patients, and as their strength increases they are given heavier work, such as reed basketry.

Class C patients are prepared for work by proper physical exercise and as soon as possible take up arts and crafts work—such as basketry, carving, toy-making, art metal work, picture frame making, engraving, etc. Others are trained as chauffeurs, which occupation is recommended medically as an ideal employment for lung sufferers. At most of the Sanatoria special buildings have been erected to house the vocational work. Some men study the ordinary subjects of a school education. Others are learning shorthand and typewriting. All this work is in the nature of occupational therapy. The industrial re-education of men who are prevented from returning to their previous civil occupations is another problem which is being handled in the same manner as

the whole problem of the re-education of the disabled. The problem of the tuberculous soldier, however, is to be taken up more fully by Dr. Elliott later on.

Since our last Annual Convention we have distributed 7,000 reports. About these a favourable editorial has appeared in the *British Medical Journal* pointing out their practical value, especially mentioning the uniformity in the plan of our reports and the "general collation of results that are being attained in a form available for public use". It also commends the lists of institutions contained therein "affording the information so often asked for in respect to terms and conditions of admission, and also the names of responsible officials".

Our posters are sent only to those specially requesting them for educational purposes. There are now 150 sets of these being used in different places. Two sets by the Tuberculosis Commission in France, six by different health officers in England, about twenty in the United States, some of which are in American Universities. In Canada they are widely scattered. A few in different schools, colleges and Universities. Some in Provincial Health Exhibits. Some are being used by Tuberculosis, Child Welfare, and other societies, a few in factories and stores, while sets are shown in practically every sanatorium and dispensary in Canada. A number of clergymen and physicians are also using them for lecture purposes. It might be of interest as showing their wide distribution to know that they are being used by Dr. Grenfell in Labrador and also at Norway House for work among the Indians. This is situated four hundred miles north of Winnipeg, where mail is received only once in two weeks by dog train. That these posters should prove useful we may quote from a recent issue of the *British Journal of Tuberculosis*.

"Much valuable educational propaganda work is being accomplished by means of suitable poster exhibits. We have recently received a fine set of twenty panel poster cards issued by the Canadian Association for the Prevention of Tuberculosis. These are particularly effective. The lettering is clear and arresting; the diagrams and illustrations are highly instructive, and in some cases a striking effect is procured by artistic colour printing. These posters might well serve as good models for anti-tuberculosis work in the home country as well as in Britain's Overseas Dominions."

Many letters of commendation from different parts of the United States and Canada have also been received.

Our pamphlet, "What you should know about Tuberculosis", is forwarded only on request and including those in parcel lots for institutions and societies we have sent out some 10,000 during the year.

In regard to these we may quote from the Medical Officer in charge of one of the large sanatoriums: "We find these very useful in our work with the soldiers, as we put one into the hands of every new patient and great benefit is derived from them. They keep them and take them home with them".

The Provincial Health Officer of Alberta says: "We should like a further supply as we are sending out public health nurses and would like these for distribution in connection with their work, and also in connection with the fairs where the nurses will be". These pamphlets are also distributed to students, physicians and laymen, but are specially useful in the hands of patients and those subject to living with them. We have also distributed over 100,000 leaflets and a number of reprints and papers on tuberculosis.

Our secretary has addressed a number of clubs, societies, and other gatherings during the year. Special mention might be made of lectures delivered to the fifth year medical students of Toronto University and to the nurses in training from all the hospitals in Toronto. More important, however, is the increasing number of requests received at our office for material for lectures by others.

The accommodation for the tuberculous in Canada now amounts to over 3,500 beds, a great increase in the past ten years; about forty-five per cent of this increase, however, has been added during the past four years as there were only 1,800 beds available at the beginning of the war. This has been largely due to the added accommodation provided for tuberculous soldiers and the solution of the tuberculosis problem among civilians, let us hope, may be materially assisted by the work done for the soldiers.

Only about six per cent, however, of the tuberculous in Canada can now be accommodated in Sanatoria, and while every bed available is much needed and many more are still required yet we must recognize that the great majority of patients will always be treated in their homes, and the importance of proper domiciliary care must be emphasized. The value of the visiting nurse is being more and more recognized, and the increase in number so employed is highly gratifying. Tuberculosis is a house disease and the Government is to be congratulated upon its recent housing schemes which should tend to lessen the incidence and mortality from tuberculosis. May we also add our congratulations for their creation of a Federal Department of Public Health, a measure which this Association has favoured by resolutions passed at every annual meeting for many years past.

We regret to note the deaths during the past year of no less than four officers of our Association. His Grace the Most Reverend Charles Hamilton, D.D., of Ottawa; Professor Frank Westbrook, President of

the British Columbia University; and Mrs. P. D. Crerar, of Hamilton, were all Vice-Presidents of this Association and had taken a most active interest in the anti-tuberculosis movement both in their own localities and in our own Canadian Association. The loss of such leaders and altruistic members of our Association will be hard to fill and their example of devoted interest in such a public movement will we trust be an inspiration to others. In the loss of Dr. E. P. Lachapelle, of Montreal, we miss not only his winning personality but his kindly and intelligent counsels as he had not only a sanatorium of continental reputation but was a man of fine public spirit as well.

As showing the importance of the tuberculosis problem in Canada, we might point out that the number of Canadian soldiers killed in action or dying from wounds during the war amounted to 50,869, and the losses in the Canadian Army through disease, of which tuberculosis had its share, were 3,940, making a total of 54,919. We have had between forty and fifty thousand deaths from tuberculosis in Canada during the period of the war—a number approximating those of our soldiers killed in the war. In this connection we might quote from a recent address by our former President, Professor J. F. Adami, before the Medical Society of London on the Physical Census. In this he says that among the causes leading to rejections from the Army, tuberculosis accounts for about one-third, and he also points out the interesting fact that the majority of these cases had been previously unsuspected until diagnosed by the medical boards.

Lloyd George is quoted as saying that "We could have put into the fighting ranks, if the health of the country had been properly looked after, at least one million more men". That the conservation of the health and the lines of our people in times of peace is of first importance, as it is during war time, is self-evident, and the annual death rate of over ten thousand from tuberculosis in Canada makes the control of this disease one of our most important health problems.

If then the steps essential for its control, as we believe, involve a proper survey, a dispensary system and home nursing as well as hospitals, sanatoria and preventoria, a pure milk supply and also a radical change in our housing problem, which is really the tap root of it all, how are we to get these things without education? This is the function of our Association and its kindred associations throughout the Dominion and for that work we look to the medical profession for leadership and to public spirited citizens everywhere and to the Government for co-operation and help.

A Plan for a More Effective Federal and State Health Administration.

FREDERICK L. HOFFMANN, LL.D.

Third Vice-President and Statistician the Prudential Insurance Company of America

(Continued from our last issue).

TOWN PLANNING AND HOUSING

The intimate relation of housing to health is clearly recognized, but, speaking generally, the best available knowledge on the subject is not applied to the successful solution of present-day problems. Of the many housing surveys which have been made, perhaps one of the most useful from the medical viewpoint is "A Study of the Housing and Social Conditions in Selected Districts of Philadelphia", by Dr. Frank A. Crane, contributed to the Eleventh Annual Report of the Henry Phipps Institute. Considered merely in its immediate hygienic aspects, the housing problem is, however, but a part of the much larger question of city planning. The many reports which have been made give evidence of the absence of uniformity to thoroughly well-considered standards. City planning, of course, includes much more than the obvious considerations of health and well-being, but no plan or method can be considered satisfactory which does not rest upon fundamental principles of hygiene. Among the more recent investigations a report on "The Development and Present Status of City Planning in New York City", prepared by the Advisory Commission of the Board of Estimate and Apportionment, may be referred to as a model of concise presentation of essential facts and principles, although no specific references are made to housing in relation to health. A report on a more elaborate scale has been issued by the City Plan Commission of Newark, N.J., including observations on the water front and waterways, markets, parks, housing, etc., but in this case also there is an almost complete absence of evidence that the sanitary engineering aspects of the problem were properly taken into account. To omit important sanitary considerations from city planning is as irrational as to omit such considerations from house planning or the construction of public buildings. To give priority to a chitectural or aesthetic considerations must necessarily lead in many cases to seriously injurious results. Most of our American cities are far from as attractive as places of residence as they could easily be made, if there were more rigid conformity to accepted principles of city and town planning, and the same conclusion applies to considerations of health and physical well-being.

The modern tendency towards so-called "garden cities" is deserving of every possible encouragement, if only on hygienic grounds. The relation of overcrowding to ill-health is clearly recognized, and the alleged necessity for such overcrowding is frequently merely a matter of economic consideration—or, even worse, of a deliberate encouragement of wrongful speculation in housing and land values. What may be achieved by means of the garden city movement has been made very clear by such contributions as those of Ewart G. Culpin, the Secretary to the Garden Cities and Town-Planning Association of England. Another English author, J. E. Hutton, Manager of the Labour and Catering Department of Vickers, Ltd., emphasizes with commendable brevity the essential facts of welfare and housing, including useful and extended observations on hospitals and medical services. In England the Local Government Board reports annually upon housing and town planning, in clear recognition of the fact that this subject is now one of serious government concern. The problem is, of course, as much one of rural as of urban hygiene, since much evidence has been forthcoming of far from satisfactory housing conditions in rural sections. A very convenient summary of facts and information on the whole subjects of housing and town planning is presented in the Annual Proceedings of the American Academy of Political and Social Science for January, 1914. It is regrettable, however, that although practically every social and economic phase of the subject was made one of extended consideration, the health and hygienic aspects of housing and town planning were entirely ignored. There is, therefore, much urgency for a more active government interest in all that is comprehended under the general term of urban sanitation, housing and town planning, if the required further reduction in the urban death rate, especially from tuberculosis and the acute infectious diseases of infancy is to be achieved within a measurable period of time.

A STATES RELATIONS SERVICE

The States Relations Service section rests upon the conception that the time is near when the Federal Government should provide its share of funds in the furtherance of the working out of a rational public health policy for every section and subsection of the United States. The constitutional difficulties of such coordination seem to have been successfully overcome in the States Relations Service of the Department of Agriculture, and the expansion of the same principle in interstate highway construction, etc. It would seem entirely sound that the share of the nation in the general sanitary administration of the country should be one-third of the total cost, provided standardized requirements of service are demanded of the local authorities, upon whom would fall

the burden of providing the other two-thirds of the cost, which again might be divided between the State (assuming one-third) and the county or municipality (assuming the other third). It is only upon some such principle as this that a perfect working plan of co-operation and coordination is ever likely to be developed. Unless the Federal Government has a direct financial interest in local plans and purposes of sanitary administration there can never be a truly national health interest, sustained by a national policy of public welfare.

Since the functions of the States Relations Service are generally not well understood, the following statement from the Annual Report of the Director of the Service for the year ending June 30th, 1918, may prove of interest: "The States Relations Service represents the Secretary of Agriculture in his relations with the State Agricultural Colleges and Experiment Stations under the Acts of Congress, granting funds to these institutions for agricultural experiment stations and co-operative extension work in agriculture and home economics, and in carrying out the provisions of the Acts of Congress making appropriations to the Department of Agriculture for farmers' co-operative demonstration work, investigations relating to agricultural schools, farmers' institutes and home economics, and the maintenance of Agricultural Experiment Stations in Alaska, Hawaii, Porto Rico and Guam. During the fiscal year 1918 the service directly administered regular and emergency appropriations aggregating \$6,016,060, and had administrative and advisory relations regarding the expenditure of \$3,520,000 of Federal funds and \$1,600,000 of State funds used as an offset for Federal funds under the co-operative extension act. In addition, the agricultural colleges and experiment stations used in experimental and extension enterprises over \$7,000,000 derived from sources within the States". On June 30th, 1918, the force carried on the rolls of the States Relations Service aggregated about 6,800 employees. It may be said in this connection that the Office of Home Economics "includes investigations relative to food, clothing and household equipment and management". The suggestion, therefore, that the Federal Government should extend financial aid in a similar manner, possibly on the basis of one-third of the total expenditures in the furtherance of approved plans of urban and rural sanitation, would not seem to imply a strained construction of Federal responsibility, nor an undue or undesirable enlargement of Federal power.

COMMUNICABLE AND TRANSMISSIBLE DISEASES

The section on communicable and transmissible diseases logically follows the section on international and maritime quarantine. Now that practically all the State quarantine stations have been transferred

to the Federal Government the effectiveness of Federal quarantine laws, rules and regulations has been very materially increased. Whether it would be wise to include in this section the medical inspection of immigrants is open to question; possibly a subsection might be created, to be known as "Immigration Service", for in many cases quarantine administration and immigration inspection are carried on by Federal officers within the same or adjoining premises, and possibly by the same medical officer. Since the primary purpose of all quarantine is to control the spread of communicable diseases, it would seem best that, in the logical order of arrangement, the latter should follow the former, even though much, if not most, of the work in connection therewith on the part of the Federal Government would, unless present methods are materially changed, consist of epidemiological research and emergency work.

SANITARY SURVEYS

The urgency of qualified sanitary and social surveys would hardly seem to require extended consideration. The fundamental principles, however, which should underlie such surveys are far from being thoroughly understood and they are frequently entirely disregarded in so-called "health surveys" of even representative communities. In most of the so-called surveys the absolutely required division of essential technical functions is rarely adhered to. Various subjects or groups of facts are frequently considered by a single investigator or director, who at best may be but a specialist in a single and strictly circumscribed branch of sanitary science. For general purposes, of course, even a superficial investigation may be useful and prove sufficient as a basis for urgently required immediate reforms. Thus, for illustration, the sanitary survey of Charleston, West Virginia, by Mayo Tolman, Director and Chief Engineer of the West Virginia State Department of Health, may be said to be a model investigation within the restricted sense of the term. Not even an expert sanitary engineer can be expected to do entire justice to the wide range of subjects generally included in such a survey, from infant mortality and the transmissible or communicable diseases to food, milk, housing and sanitary nuisances.

Thus far in most of our States and localities the required special technical ability of a high order has been wanting to provide an adequate staff of experts for a sanitary survey in strict conformity to modern standards of accuracy and thoroughness. There has not been forthcoming, for illustration, such a thorough investigation as has been made of the sanitary problems, present and future, of the city of Dublin, Ireland. Too often it is taken for granted that any sanitary official,

qualified in a restricted field of public activity, is also competent to express an opinion and advance even radical recommendations concerning the numerous and frequently very important questions involved in investigations of this kind. The increasing demand for such surveys, therefore, suggests the need of higher standards of inquiry, such as can result only from the deliberations of qualified experts of the first rank, usually to be found in the employ of the Public Health Service of the Federal Government or of the health departments of the larger and more progressive States. The required standard methods of inquiry are more likely to be adopted if approved and recommended by a Federal Health Administration than by State authority or sanitary experts in private practice.

Sanitary surveys in the more general sense of the term to which attention may be directed are the Reports on Public Health in Springfield, Illinois, by Frank Schneider, of the Russell Sage Foundation, New York, 1915; The Health Survey of New Haven, by C. E. A. Winslow, James Cowan Greenway and David Greenberg, of Yale University; the Lawrence, Massachusetts, Survey, prepared jointly by Francis H. McLean, Arthur D. Marble, Robert E. Todd and Frank B. Sanborn; and the Lawrence, Kansas, Social Survey, made under the direction of Prof. F. W. Blackmar, a sociologist of the first rank, and including a section on school sanitation, with a number of tables of physical measurements of Lawrence school children, and an analysis of sickness statistics and the results of physical examinations, particularly of eyesight and dentition.

None of these investigations can be considered entirely satisfactory, though each and all are useful in their way, as indications of an aroused interest in the underlying facts and conditions which determine the health of the community. The ultimate attainment of the ideal would seem to lie in the direction of the method which has been so successful on the part of the U.S. Bureau of Soils, which has issued a large number of special reports of selected areas, for which the prevailing soil types, their fertility and agricultural use have been determined. Probably 15 per cent. or more of the entire area of the United States has gradually been surveyed in this manner, and wherever feasible the topographic atlas sheets of the U.S. Geological Survey have been utilized. Under a thoroughly reorganized Federal Health Administration it would become an important duty of the Government to initiate local sanitary surveys in much the same manner as this work has been carried forward by the Bureau of Soils on a basis of co-operation with State authorities. Such surveys would disclose favourable or unfavourable conditions affecting health and longevity and make the facts a matter of permanent record. There are, of course, many other special factors involved besides topography, which is here emphasized chiefly because the necessity

for an exact ascertainment of physiographic factors is so generally ignored.

An excellent illustration of a Survey of Social Agencies is an investigation of conditions in Alameda County, California, prepared by Jean Howard McDuffie for the Board of Public Welfare and published by the Board of Supervisors, Oakland, 1917. This report shows by twelve maps, amplified by numerous statistical tables, etc., the numerous agencies rendering medical assistance in the care of the sick, in public, semi-public and private hospitals, etc., home visiting or nursing, and the operations of local boards of health. The basis is here provided for a future survey in which more attention should be given to the strictly scientific technical considerations not within the plan or scope of the present inquiry. The authors of the report have rendered a real service not only to the citizenship of Alameda County, but to the country at large. A Federal Health Administration would unquestionably initiate similar investigations on a co-operative basis throughout the country and make available the required information without which further sanitary progress on a large scale is not likely to be attained.

There is naturally a close relation between sanitary surveys and proper methods of town planning, rehousing, and urban development generally. As a part of its war activities the Committee on Labour of the Advisory Commission of the Council of National Defence caused to be prepared a report on the "Sanitation of Rural Workmen's Areas with Special Reference to Housing", which is a suggestive illustration of recognized fundamental principles which only too often are disregarded, even in plans which claim to be models of their kind. As further evidence of progress, reference may be made to the Standards of the Department of Health and Sanitation of the U.S. Shipping Board Emergency Fleet Corporation, prepared by Lieut. Colonel Philip S. Doane. This report includes a useful section on mosquito eradication and control, than which there is perhaps no more important health problem connected with military or labour camps in sections in which anopheline mosquitoes prevail. The most encouraging practical illustration of progress in the United States is the group of mining villages erected under the supervision of Mr. C. L. Close by the Tennessee Coal and Iron Company of the United Steel Corporation in the vicinity of Birmingham, Alabama. In the working out of the practical details of this undertaking, which is on a considerable scale and which includes every element of community life, such as schools, playgrounds, recreation centres, infirmaries, hospitals, etc., the fundamental principle has not been lost sight of that the essentials of housing include all the essentials of *home life*, and it is most gratifying to be able to say that no race discrimination has been practised, but that the cottages and surroundings are identical for both the white and the coloured employees.

Social Background

Report of the Sub Committee on Dependency of the Children's
Committee of the National Conference
of Social Work.

Atlantic City — June 1919,

C. V. WILLIAMS, Chairman

THREE has been neither time nor opportunity for the Committee to prepare at this time more than a preliminary report covering a few fundamentals which govern the philosophy of the treatment of the dependent child.

There has been great progress in child-caring methods during the past few years, shown not only in higher standards maintained by a number of organizations, but also in the development of a sense of community responsibility which in some states has expressed itself in the working out of definite programs. The Committee would refer most enthusiastically to the altruistic activities of thousands of men and women who have been spending their time and their money in the care and in the protection of needy children, and especially would it refer to the heroic service which was rendered by many unnamed heroes and heroines during the influenza epidemic. But the Committee is of the opinion that it is of far greater importance to call the attention of this conference to unfinished work and unsolved problems than to permit a feeling of satisfaction and complacency over the accomplishments which have resulted in our reaching but a small part of our problem.

On the occasion of the Washington Conference called ten years ago, now historically known as the White House Conference, fourteen resolutions were unanimously adopted. The group of people passing these resolutions were most representative. But if we are to judge by results, a considerable proportion of the persons engaged in child caring work have not been giving serious consideration to some of the principles represented by these conclusions. We will again ask your consideration of the provisions represented by some of these resolutions:

Home Care.—“Children of worthy parents or deserving mothers should, as a rule, be kept with their parents at home.”

Not only are the children of many living worthy parents still detained in institutions, but some child-caring organizations are permitting

worthy distressed mothers to relinquish, unnecessarily, their children to the permanent guardianship of their organizations.

Preventive Work.—"The effort should be made to eradicate causes of dependency, such as disease and accident, and to substitute compensation and insurance for relief".

In many sections of the country the major effort is exercised in the actual care of the children from broken or destroyed homes, while comparatively little effort is made to bring about family rehabilitation or the removal of the causes of poverty. Vast sums of money are appropriated for the erection of buildings for the care of dependent children in communities where family service of a preventive nature properly directed would make possible the care of many of these children by their parents.

Home Finding.—"Homeless and neglected children, if normal, should be cared for in families when practicable".

An immense number of children who are physically and mentally normal and who, for various reasons, cannot be returned to their own parents, are subjected to continued custodial care in institutions throughout the country. A large sum of money is thus unnecessarily spent in housing children while depriving them of the advantages of normal family life.

State Inspection.—"The State should inspect the work of all agencies which care for dependent children".

The supervision by the State of child-caring agencies has not been everywhere provided, and shameful neglect of dependent children has prevailed in some such States where there is no provision for the standardizing and the regulating of child-caring agencies.

Facts and Records.—"Complete histories of dependent children and their parents based upon personal investigation and supervision, should be recorded for guidance of child-caring agencies".

Little or no effort is made by some of the agencies either to secure or to preserve the family history of the dependent child. The Court adjudication of dependency resulting in the permanent separation of the child from his parents has frequently been accomplished with little or no information concerning the child's antecedents.

Physical Care.—"Every needy child should receive the best medical and surgical attention, and be instructed in health and hygiene".

A number of child-caring agencies have not yet been aroused to the necessity of removing the physical handicaps of children placed in their care. Intensive physical examinations with treatment for remediable defects have been the exception rather than the rule.

The Committee would supplement this resolution with the declaration of the recognition of the value of the personality study of the child

as a requisite for his proper treatment in the Institution or for his suitable adjustment to a foster home.

Co-operation.—"Local child-caring agencies should co-operate and establish joint bureaus of information".

While in certain sections of the country there has been developed through children's bureaus councils of social agencies and kindred organizations, schemes for the co-ordination of local welfare agencies—in many parts of the country there is little co-operation between agencies engaging in the same work and much waste and duplication of effort with an immense undeveloped field.

The Committee would emphasize the fact that a sympathetic understanding by the members of this Conference, of the principles just referred to, should have resulted in the correction of many of the wrongs and abuses which are now perpetrated upon defenseless children.

The dependent or neglected child cannot receive adequate treatment when considered apart from his family, or the fragment of family from whence he comes. There is no child problem, which is not a family problem, and no family problem which is not a community problem. We must develop the forces within the community that will develop and conserve the latent impulses for good which may be discovered in even the so-called bad family.

The State must assume the responsibility for the care of its children as an economic principle; it is reprehensible and extravagant for a community to fail to provide needed and adequate protection at all times for all of its children, and such protection should be extended alike to all classes and races; the community which prides itself upon the establishment of agencies caring for some of the needy children permitting others to be subject to neglect has failed to meet its opportunity and will later have to face the consequences incident to child neglect.

The Committee recommended for each community the development of a program which will ally all of its altruistic forces, and the membership should not be limited to the agencies specializing in child care. The child should be discovered and treated before dependency has marked him sufficiently to attract the attention of the service agency. The nature of the organization will vary to meet the community needs but the central agency should be composed of representatives of all of the organizations engaged in community welfare. Such an organization will be in possession of the potential possibilities of all of the co-ordinated agencies, and its development makes possible the defining of the responsibility of each agency and the intensifying of its work. Only through such co-ordination is community diagnosis with remediable treatment made possible. Until all of the forces of the community for

public betterment are united in such an effort, many children will be sacrificed.

The practice common to many of our child-caring associations in most of the States, of permitting a parent to transfer to the agency the permanent guardianship of his child, without confirmation by a court of competent jurisdiction, is cruel and this practice should be everywhere abolished. In many sections of the country, with very little formality, a mother may sign away her right to her child while lying upon a sick-bed in a maternity hospital, and this scrap of paper, unacknowledged, is accepted by an adopting court as sufficient justification for permitting the adoption of a child to another. These surrenders or releases are not infrequently executed at a time when the parents are temporarily distressed and neither physically nor mentally able to know what they ought to do, and are at times instigated by enthusiastic agents desirous of securing attractive children for prospective foster homes.

The crude and inadequate adoption laws in force in many of our states resulting in the summary adoption of children by unfit persons should be replaced by legislation which will place upon an adopting court the same responsibility for investigating the facts concerning the child and also the foster family as are recognized as minimums to be employed by qualified child-caring agencies.

Supervision by the state should be extended to all agencies, public or private, incorporated or otherwise, as receive or care for children or place children in family homes. This supervision should include the activities of individuals who care for children for hire, gain, or reward not related by blood or marriage. But this supervision should be sympathetic, helpful and constructive, and should be exercised so as to provide for the conservation of the altruistic activities of the agencies supervised.

The Committee would recommend the intensive study of the following subjects, where there is a marked difference of opinion:

JUVENILE COURTS

The juvenile court has been established in many parts of the country with broad powers looking to the protection of dependent and delinquent children. In some states the court administers the distribution of mothers' relief and is engaged in the actual care of dependent children. Some of these children are cared for in detention homes or institutions under the supervision of the court, and others are placed in foster families. In some of the states judges of other jurisdiction, elected by popular vote, share the juvenile court responsibility.

The Committee raises the question as to the wisdom of this procedure. To what extent should the juvenile court operate as an administrative agency in the treatment of dependent children? Is the continuing jurisdiction of the juvenile court over the wards committed to the permanent care of a placing-out agency for placement in family homes in advantage or a detriment?

Should cases of dependent children, where there is no parental neglect, be brought into the juvenile court for adjudication?

THE RESPONSIBILITY OF THE STATE AND PRIVATE AGENCIES IN THE CARE OF DEPENDENT CHILDREN

The Committee would raise the question as to the distribution of responsibility by public and private agencies for the care of all of the dependent children, that the State should assume the primary and ultimate responsibility, and that it should standardize and utilize all of its agencies to a maximum degree there is no question. But what proportion of responsibility for the direct care of the child should be assumed by the State? In some States there is a very definite exercise of responsibility shown either through a board of children's guardians, a state board of charities, a children's bureau, or through the state public school; while in other states the burden of responsibility for the care of all its dependent and homeless children, to what extent should it employ the service of the private agencies? There are persons connected with private organizations who will show that there is an immense amount of voluntary altruistic service which could not be developed nor controlled by the State. This is especially true of religious or church organizations. They will, moreover, show that any attempt by the state to take over work which is already being well done will tend to dry up streams of charity and benevolence which the state needs. And they will also show that the community itself is better because of the opportunity given to its citizens to participate in these humanitarian efforts. On the other hand there are persons who will show that the private agencies cannot adequately cover the field of child-caring, and in consequence of the failure of the state to provide machinery, large numbers of children are sacrificed. What shall be the division of responsibility between the public and private agencies?

MOTHERS' PENSIONS

The study of the administration of mothers' pensions in some of the states reveals the fact that the amount of money available for distribution is woefully inadequate, and the machinery for investigation and supervision in many instances insufficient, while the law contemplated

a providing of sufficient funds to the mother in order that she might remain at home with her children, in actual practice the amount of money available has sometimes been insufficient to pay the rent, and while material assistance has been given, the problem has not been solved, and the mother, after a terrific struggle, ultimately has been obliged to part with her children.

This system of providing partial relief to mothers demands most intensive study.

We would recommend the appointment of a Committee to continue the work during the coming year, and that the program of the Committee be the consideration of the following subjects:

INTRODUCTION OF FOREWORD

1. Historical background of work for dependent children.
2. Definition of terms employed in the treatment of the dependent child.
3. Standards employed by organizations in their first contact with cases.
4. Types of cases and methods of treatment and care.
5. Minimum standards in the care and treatment of dependent children in the terms of each child.
6. Application of treatment.
 - (a) In his own family.
 - (b) In a foster home.
 - I. At board.
 - II. In a free home.
 - III. In a wage home.
 - IV. In an adoption home.
 - (c) Institutions.
7. Function of state and local communities in care and treatment of dependent child.
 - (a) State responsibility and its relation to private agencies.
 - (b) Development of community plans.
 - (c) Juvenile Court—Family Court.
 - (d) Mothers' Aid.

Each of these subjects should be assigned—one to each member of the Committee who in its preparation should seek all available data and should call to his aid such persons who will be most helpful. These reports should be co-ordinated, edited and printed before the next National Conference.

The best child-caring agencies of the country have not yet satisfactorily provided a program that adequately protects all of its wards

at all times. We have indications of an awakened consciousness of the rights of defenseless children, when such a publication as the *Delineator* in its present Child's Welfare program seeks to best serve the neglected children of a nation by employing the technique and utilizing the experience of the standardized agencies of the country in working out the child's whole problem.

If child neglect continues in the community in which we live to a large degree we are responsible. Representing the leading agencies of the entire nation there is placed upon us the responsibility for the development of constructive propaganda which will safeguard our children. If our low standards are occasioned because of financial limitations, we have within us the ability as well as the power to educate the community in which we live. If the organization which we represent is not intensifying its work and expanding to meet growing community needs, it is failing in its possibilities. What of it if our organizations with their complex machinery maintained at an immense cost have saved a few children? Are we to remain indifferent to the needs of thousands of children in our country to-day subjected to extreme neglect because of our failure? This Conference will not have done its duty unless it has some anxious moments concerning its responsibility to the unreach^{ed} dependent child and unless it secures in every community the development of a program which will have as its minimum the adequate protection of every child.

C. V. WILLIAMS.

C.A.M.C. News

MONTH OF OCTOBER, 1919

APPOINTMENTS:

Major Harry James Shields is posted for duty under the A.D.M.S., M.D., No. 2, as part time Medical Officer.

Major Percy James Sandys Bird is posted for duty under the A.D.M.S., M.D. No. 4.

Q.M. and Hon. Lieut. Albert Price Disley is posted for duty under the A.D.M.S., M.D. No. 2.

Major George Patrick Howbett is posted for duty under the A.D.M.S., M.D. No. 3.

Captain Charles Smith Henderson is posted for duty under the A.D.M.S., M.D. No. 6.

Captain Harry Knight Mitchell is posted for duty under the A.D.M.S., M.D. No. 10.

Major Darrell Porters Hannington is posted for duty under the A.D.M.S., M.D. No. 11.

Captain Robert Kells Johnston is posted for duty under the A.D.M.S., M.D. No. 3.

Captain Roswell Cameron Lyon is posted for duty under the A.D.M.S., M.D. No. 3.

Captain Sydney James Wood Horne is posted for duty under the A.D.M.S., M.D. No. 3.

Captain Oscar Glennie Donovan is posted for duty under the A.D.M.S., M.D. No. 6.

Captain James Walters Harper, C.A.M.C., is posted for duty under the A.D.M.S., M.D. No. 10.

Captain Phillip Doane McLaren is posted for duty under the A.D.M.S., M.D. No. 6.

Captain Herbert Charles Allison is posted for duty under the A.D.M.S., M.D. No. 1.

Captain Allan Martindale Yates is posted for duty under the A.D.M.S., M.D. No. 1, and is granted the rank of Major whilst employed with effect from the 24th July, 1919.

A-Major Joseph William Hunt is posted for duty under the A.D.M.S., M.D. No. 2.

Captain Douglas Wallace is posted for duty under the A.D.M.S., M.D. No. 10. Vice-Captain R. B. Jenkins, 5th October, 1919.

Q.M. and Hon. Captain Arthur William Holmes is posted for duty under the A.D.M.S., D.G.M.S. Militia Headquarters, Ottawa, 10th October, 1919.

Captain Harold Ewing Preston is detailed for duty under the Director of Internment operations as Medical Officer-in-charge of party insane prisoners of war being repatriated to Germany, 25th October, 1919.

Captain Morley Edward Gorman is detailed for special duty in the Directorate of the D.G.M.S. Militia Headquarters, Ottawa, 16th October, 1919.

Major John Phillip Selby Cathcart, M.C., is detailed for duty under the A.D.M.S., M.D. No. 2, 6th October, 1919.

PROMOTIONS:

The undermentioned Temp. Lt.-Cols. (acting Cols. to be Cols.):

C. P. Templeton, D.S.O., 18th January, 1919.

E. L. Stone, 1st August, 1919.

J. S. Jenkins, D.S.O., 15th January, 1919.

C. Hunter.

W. T. Lochart, 1st August, 1919.

C. E. F. Haszard, 1st August, 1919.

The undermentioned Temp. Capts. Acting Majors to be Temp. Majors:

H. W. Wadge, M.C., 15th January, 1919.

P. J. S. Bird, 30th July, 1919.

J. D. Jones, 1st August, 1919.

J. S. Fitzsimons, 1st August.

J. W. Hunt, 1st August, 1919.

A. B. Wilks, 21st August, 1919.

The undermentioned Temp. Capt. (Acting Majors to be Temp. Majors):

D. S. Morris, 2nd June.

S. Sprague, 9th August, 1919.

G. O. Scott, 23rd August, 1919.

Temp. Major (acting) Lt.-Col. F. E. Watts to be Lt.-Col., 29th July, 1919.

Temp. Captain A. N. Aitken relinquishes the Acting rank of Major, 23rd August, 1919.

Temp. Major (Acting) Lt.-Col. L. H. McKim relinquishes the acting rank of Lt.-Col., 25th June, 1919.

Temp. Captain E. F. Risdon to be Acting Major whilst employed as Officer i/c Canadian Section of Plastic Surgery, 2nd May, 1919.

RETURNED FROM OVERSEAS:

The undermentioned officers are returned from Overseas on general demobilization:

Captain Robert Lindsay Morrison.
Captain George Frederick Seaborn.
Major Thomas McL. Creighton.
Lt.-Col. Allan C. Rankin.
Major Charles John Currie.
Captain Allison Taylor.
Captain Benson Ambrose Cohee.
Captain Gerald Joseph Lunz.
Captain Frederick James Snelgrove.
Captain William Thompson Kennedy.
Captain James Grant Strachan.
Q.M. and Hon. Captain James Forester Christie.
Q.M. and Hon. Captain George Alexander Bell.
Captain Melville Allan Oulton.
Captain James Currie McWilliam.
Captain Joseph Picard.
Major John Henry Birch.
Captain Frank Hastings Mewburn.
Captain Herbert Legear Collins.
Major Stayner Ellis.
Captain Robert Willison Brulls.
Lieut. Howard Owen Jones.
Captain Harold Wilbert Street.
Captain William Lindsay Gradyon.
Captain Herbert Henry Eyres.
Captain James Arthurson McEwen.
Captain Henry Joseph Robillard.
Captain Ralph Newton Tripp.
Captain George Duncan McTagart.
Captain Gordonsmith McAlpine.
Captain William Alfred Jones.
Captain William Harold Baillie.
Captain William Allan Clayton.
Captain Archibald Donald Campbell.
Captain John Kenneth McBane.
Captain Albert George Toy.
Captain Wilbert Harold Eby.
Captain Horace Watson Kerfoot.
Captain Thomas D. Bennett.
Lt.-Col. Allan Coates Rankin.

Captain George Alonzo Simons.
Captain Francis George Wallbridge.
Major Harold Bentley Boyd.
Major Frederick Beheimer Bowman.
Major Arthur Brown James.
Major Harley Smith.
Major John Cotton Maynard.
Major Joseph William Hunt.
Colonel Frederick Guest.
Captain Hartly Robert Conn.
Captain Kenneth McKim Shorby.
Major Ralph R. Barker.
Major James Robert Goodall.
Major Edgar Douglas.
Lt.-Col. William Wilby Nasmyth.
Lt.-Col. Fred Holland MacKay.
Captain Frank Russell Hastings.
Major George Orville Scott.
Q.M. and Hon. Captain Russell Alwyn Scott.
Lt.-Col. Hugh Ernest McDermot.
A-Lt.-Col. Williams Turner Lochart.
Lt.-Col. Sturgeon Campbell.
Captain Charles Bouck.
Captain Edgar Alexander Campbell.
Captain Elmer Tilley Kennedy.
Captain James Stanley Chisolm.
Captain Joseph Blake.
Captain Victor George Williams.
Captain Cecil B. Corbett.
Colonel Alexander Primrose.
Major Ewart Wilson.
Captain James Moore.
Captain George Cleveland Wagner.
Captain Williams Arthur Love.
Captain Edward Chritian Pough.
Lieut. Howard Owen Jones.
Major Harry James Shields.
Major Frederick Clarence Clarke.
Captain George McManes Carson.
Captain Roy Bertram Jenkins.
Captain John Alexander Young.
Captain Robert Ritchie Walker.
Captain John Thompson Green.

Captain Cecil Alexander Rae.
Captain John Francis Haszard.
Captain Floyd Cecil Stewart.
Q.M. and Hon. Lieut. Frederick Pock.
Major Allan Buck.
Captain Cecil Alexander Rae.
Captain Harry Coppinger.
Captain Morton Eldred Hall.
Captain Alfred Errington Shore.
Captain Murdock Alexander MacKinnon.
Captain Frederick James Brodie.
Captain George Aldon Greaves.
Captain William Filmer Coy.
Major Allan Beech.
Lt.-Col. Frank Cornwall McTavish.
Major James Thomas Wall.
Major Alva Burton Chapman.
Major Frederick William Lees.
Captain James Fisher Weir.
Captain George Alexander Ramsay.
Captain Neil Douglas Black.
Captain Lloyd Lawrence Buck.
Captain Alban Foote Foss.
Captain Joseph Peter Bilodeau.
Captain Alexander Archibald.
Q.M. and Hon. Captain David Stanley Ruthledge.
Q.M. and Hon. Captain Henery Maurice Cody.
Lieut. William Rankin.
Captain Lawrence Noble Armstrong.
Captain Oscar Frederick Eastman.
Captain Archibald Henderson McLaren.
Lt.-Col. Archibald Lorne Campbell Gilday.
Captain Joseph Austin Keely.
Captain Andrew Campbell McCormack.
Captain George Hooper.
Captain Irvin John Leatherdale.
Lieut. Lloyd Cecil Rymal.
Captain Frederick Fitzgerald Tisdall.
Major Arthur Wallace Bagnall.
Lieut. George Richard.
Captain Hammett Alonzo Dixon.
Captain John Russell Christian.
Captain Edmund Boyd.

Captain Frederick Charles Marlow.
Captain Charles Joseph Garofalo.
Captain Edward Charles Arthur.
Captain Joseph Pheonix De Cossie.

RETIREMENTS:

Captain John Broadfoot Jupp, C.A.M.C., 30th June, 1919.
Captain Edmund Percy Lewis, C.A.M.C., 11th September.
Lieut. William Hugh Holmes, 15th September, 1919.
The undermentioned Temp. Capts. retire in the British Isles, 9th August, 1919:
E. Worshaf.
J. P. Bonfield, M.C.
A. E. Wood, 1st August, 1919.
H. C. Clermont, 9th August, 1919.
H. L. Walker, 15th August, 1919.
F. A. O'Reilly, 16th July, 1919.
Temp. Captain J. A. Houston retires in the British Isles, 11th August.
Temp. Captain R. G. Moffatt, 3rd August, 1919.
Temp. Captain J. P. S. Cathcart, M.C., to be Temp. Major, 21st May, 1919, (substituted for Gazette notification, 11th August, 1919).

TO BE MAJOR:

Major Albert Joseph Fisher, 17th September, 1919.
Lieut. Charles Percival Garbutt, C.A.M.C., 12th August, 1919.
Major Henry Ormsby Boyd, 15th July, 1919.
Captain Robert Maitland Cook, 2nd June, 1919.
Captain Clare Annis Langmaid, 1st July, 1919.
The undermentioned officers retire in the British Isles:
Temp. Captain A. R. Campbell, M.C., 31st August, 1919.
Hon. Captain J. C. McClure, 1st August, 1919.
The undermentioned Temp. Capts. retire in the British Isles:
W. A. McClelland, 16th August, 1919.
A. N. Aitken, 23rd August, 1919.
Temp. Captain E. E. Locke, retires in the British Isles, 3rd September, 1919.
The undermentioned officers retire in the British Isles:
Temp. Major N. G. Cooper, 1st September, 1919.
Temp. Captain H. W. Bell, 29th August, 1919.
The undermentioned Temp. Capts. retire in the British Isles:
W. A. Marshall, 9th August, 1919.
P. A. Leacy, 9th August, 1919.
W. H. Hills, 9th August, 1919.

C. V. Hills, 9th August, 1919.
H. R. Boc, 9th August, 1919.
H. H. Perry, 9th August, 1919.
The undermentioned Tem. Officers retire in the British Isles:
Temp. Captain R. McKinlay, 11th July, 1919.
Temp. Capt. J. L. Porier, 26th July, 1919.
Temp. Captain A. W. Begg, 28th July, 1919.
Temp. Lt.-Col. E. L. Pope, 31st July, 1919.
Temp. Captain G. B. Ferguson, 31st July, 1919.
Major (Temp.) D. J. Cochrane, 1st August, 1919.
Captain D. Smith, 1st August, 1919.
Temp. Captain R. F. Proce, 1st August, 1919.
Temp. Captain H. G. McCarthy, 1st August, 1919.
Temp. Captain W. G. Lowery, 1st August, 1919.
Temp. Captain M. F. B. Graham, 1st August, 1919.
Temp. Captain V. K. O'Gorman, 1st August, 1919.
Temp. Captain B. Cohen, 1st August, 1919.
Temp. Col. W. K. Watt, 5th August, 1919.
Hon. Lieut. and Q.M. Mr. H. Skuce, 8th August, 1919.



The Provincial Board of Health of Ontario

Salary of Medical Officer of Health of the Town of Port Hope.

Judge Ward Fixes Salary at \$600 per year and Orders Town to Pay Costs.

His Honor Judge Ward has given out the following judgment in the case of Dr. G. A. Dickinson, Medical Officer of Health, *vs.* the Town of Port Hope. His Honour decides in favour of Dr. Dickinson and fixes his salary at \$600 per year. The town pays all expenses.

JUDGMENT

The Public Health Act (section 35) requires the Council of every municipality to appoint a legally qualified medical practitioner to be the Medical Officer of Health for the municipality, and (section 39) provides that he is to be paid by the Municipal Corporation a reasonable salary, and by Section 52a (an amendment to the Public Health Act by Chapter 41, Section 7, Ontario Statutes, 1918) when a Medical Health Officer claims that the salary paid to him by the Municipal Corporation is not fair and reasonable, he may apply to the County Judge for an order fixing the amount payable to him as salary under section 39, or as remuneration under section 52a.

I have heard the parties and their witnesses.

Dr. George A. Dickinson was first appointed Medical Officer of Health for Port Hope in 1902, at a salary of \$50 per annum, when apparently the duties of the Officer were chiefly permissive, and in 1912, when the duties had become by statutory enactment in a large sense obligatory, his salary was fixed at \$500 per annum, and this rate continued until the 30th day of September, 1918, when the Council of the Municipal Corporation passed a By-Law, number 1201, reducing the salary of the Medical Health Officer to \$300 per annum.

Upon a careful consideration of the evidence of the applicant, and the volume of Exhibits filed, showing the work done by him, I am inclined to believe that the action of the Council was hasty and unwise.

After such drastic action, it might fairly be expected that the members of the Council would be prepared to back up the course they had pursued during the progress of this enquiry, but only His Worship the Mayor and three of the Members of Council gave evidence before me.

His Worship and Councillor Davison alone, had any fault to find with the Medical Health Officer, while Councillor Fulford spoke most favourably of his efficiency and work, and Councillor Smith neither blamed nor praised.

In view of the importance of this matter, affecting as it does, the vital interest of the community, it is difficult to understand the apathy and indifference displayed throughout the enquiry by many of the members of the Council, the Press, and the Citizens generally. The public should, in my judgment, have been allowed to read from day to day the evidence given at an enquiry of this nature so that each individual could read for himself and form his own conclusions.

It would be impossible for me, in this order, to refer in detail to the inspections, reports and other work performed by the Medical Health Officer, as required by the Public Health Act, and other enactments of the Legislature, and proved to have been done by the mass of reports, books and documents filed; but I will mention one which appears to be of special value: Shortly after Dr. Dickinson's appointment in 1912, he undertook to supply a sanitary survey of the town, showing every house the name of its owner, the street where situated and its conveniences in detail; this work occupied its author, during his spare time, for about ten months, in the year 1912 and 1913, and is and has been, I have no doubt, of great value to the Local Board of Health ever since its completion.

I find, therefore, upon the evidence, that, in the main, the work of the Medical Health Officer has been well and efficiently performed, and that he is entitled to fair and reasonable remuneration. If there are any serious grounds for the complaints of His Worship the Mayor and Councillor Davison, I would call attention to the fact that Medical Health Officers are the servants of the Corporation employing them, and it is their manifest duty, at all times, to be courteous and obliging to the officials of the town, and to furnish all reasonable information asked for; it is also their duty when any question affecting the health of the town arises, to act promptly and fearlessly without regard to the convenience or interest of any individual citizen.

Now, as to what is a reasonable remuneration; I have read the memorandum showing salaries paid to Medical Health Officers in other municipalities of the size and importance of Port Hope, but I am not inclined to allow this to influence my judgment as I believe that these municipalities are getting in service what they pay for and no more, and

I think the people of Port Hope expect and require proper and effective service where the health of the town is concerned.

Neither am I inclined to pay too much attention to the figures mentioned by the medical witnesses, called by the applicant, as perhaps these gentlemen's ideas were based upon the amount for which they would be willing to undertake the work.

The Statute points out that the Judge, upon the application, shall take into consideration all the circumstances of the case, and amongst others, the physical extent, population and assessment of the municipality.

The circumstances, in this particular case, are many and varied, both for and against a large amount of remuneration being awarded, and I must say frankly that I am, to a certain extent, influenced by the high rate of taxation which prevails at the present time.

After a careful review of the evidence, and of all these circumstances, I am of opinion that the Medical Health Officer of the town of Port Hope should be paid yearly the sum of \$600.

I, therefore, make an order allowing the claim made by Dr. G. A. Dickinson, and I fix the amount payable to him, as salary under Section 39 of the Public Health Act at \$600 per annum.

I further order that the costs of this enquiry be paid by the town of Port Hope.

Dated this twentieth day of October, A.D., 1919.

(Signed) H. A. WARD, Judge.

COMPARATIVE TABLE

Diseases	1919		1918	
	Cases	Deaths	Cases	Deaths
Smallpox.....	38	0	6	0
Scarlet Fever.....	277	2	187	3
Diphtheria.....	452	49	351	52
Measles.....	96	1	188	4
Whooping Cough.....	166	6	72	31
Typhoid Fever.....	98	21	111	31
Tuberculosis.....	169	135	259	181
Infantile Paralysis.....	14	1	2	0
Cerebro-Spinal Meningitis.....	5	3	6	4
Influenza.....	10	3	0	0
Acute Influenzal Pneumonia.....	0	11	0	0
Acute Primary Pneumonia.....	..	125
Relapsing Fever and Dysentery.....	..	1
	—	—	—	—
	1,325	358	1,182	306

NOTE.—The last four diseases were not reported in 1918.

VENEREAL DISEASES REPORTED BY MEDICAL OFFICERS
OF HEALTH FOR OCTOBER, 1919

<i>Diseases</i>	Oct. 1919	Oct. 1918
	<i>Cases</i>	<i>Cases</i>
Syphilis.....	79	56
Gonorrhoea.....	121	191
Chancroid.....	3	4
	<hr/> 203	<hr/> 251

NOTE.—Syphilis caused three deaths.

SMALLPOX REPORT FOR OCTOBER, 1919

<i>Places</i>	<i>Cases</i>
Toronto.....	3
Woodstock.....	7
Guelph Township.....	3
Aurora.....	1
Sudbury.....	2
Bobcaygeon.....	1
Elderslee.....	1
Arron.....	1
Sandwich E.....	3
Tyendeinaga.....	5
Bayfield.....	1
Widdifield.....	1
Darlington.....	2
Blandford.....	1
Oxford E.....	1
Picton.....	1
Martland.....	1
Tisdale.....	2
Eldon.....	1
	<hr/> 38

The reports of the Local Boards of Health for the month of October of communicable diseases show smallpox to be more prevalent than in the corresponding month of 1918, and is scattered over 19 municipalities, but no deaths are reported. Scarlet fever cases are 90 more with one less death. Diphtheria also has 101 more cases with 3 fewer deaths or a case mortality of 10.8. Typhoid, measles and tuberculosis show a substantial reduction compared with October of last year. Influenza and influenzal pneumonia caused 14 deaths and acute primary pneumonia 125 deaths. It is most gratifying to note the few deaths from influenza compared with October last year, when over 3,000 were reported by the undertakers.

News Items

Dr. D. A. Clark has been appointed Deputy to the Deputy Minister of Health, Federal Department of Health, Ottawa. Mr. G. A. Holland has been appointed Secretary in the same Department.

Dr. Fred. Guest of St. Thomas has been appointed District Officer of Health for No. 1 District under the Provincial Board of Health of Ontario.

Dr. George E. Smith has been made Director of the Division of Child Welfare in the Department of Health, Toronto, in succession to Dr. Alan Brown, resigned.

Dr. Eric Clarke, Toronto, has received the appointment of Psychiatrist to the Department of Health, Toronto. Dr. Clarke will carry on work amongst children in the primary grades of the Public Schools in Toronto.

An important conference was held in the office of Dr. J. W. S. McCullough, Chief Officer of Health for Ontario, on November 14th last, to consider the question of more effectively carrying out the provisions of the Venereal Diseases Prevention Act, Ontario. Amongst those present at the conference in addition to the Chief Health Officer were: Dr. C. J. Hastings, M.O.H., Toronto; Dr. Gordon Bates, General Secretary of the Canadian National Council for Combating Venereal Diseases; Professor J. G. Fitzgerald, of the University of Toronto; Dr. C. H. Haire, Dr. E. Trow and Dr. Williams, of the Special Treatment Clinic, Toronto General Hospital, also representatives from the various Military Hospitals in M.D. No. 2, and Miss E. Dyke, Miss Jane Grant, and Miss Brown, of the Division of Public Health Nurses, Department of Health, Toronto. A small sub-committee was appointed to consider the advisability of amending, in certain details, the present regulations.

Mr. M. J. Maloney, M.A., has been appointed Research Chemist in the Connaught Antitoxin Laboratories, University of Toronto.

The Massachusetts-Halifax Health Commission has begun work in Halifax, and Dr. Royer, formerly of the State Department of Health,

Pennsylvania, has been appointed Director of the Commission. The Board of Management of the Commission is made up of nine leading men of the Province, including the Provincial Health Officer, Dr. W. H. Hattie.

Mr. H. M. Lancaster, Provincial Chemist, has been appointed Director of the Laboratories of the Provincial Board of Health of Ontario to succeed Dr. John A. Amyot, C.M.G. Deputy Minister of Health, Department of Health, Canada.

Dr. R. R. McClenahan has been made Director of the Bureau of Venereal Diseases in the Provincial Board of Health of Ontario.

Editorial

A NATION-WIDE campaign is being launched as one of the first activities of the newly-created Federal Department of Health.

The Dominion authorities have granted \$200,000 to assist in combating venereal diseases, conditional upon the same amount being raised by the Provinces. Each Province will frame its own statutes and evolve its own plans, but unity from coast to coast in educational work will be given by a voluntary agency, the Canadian National Council for Combating Venereal Diseases, representing all the Provinces. This organization will endeavour to enroll members in every community in Canada and impress on the public mind the gravity of the problem. The lecture platform, the moving-picture, the newspaper, and the magazine will be used. It is probable that definite surveys will be made by trained investigators in police courts, reformatories, and jails to ascertain what can be done in a preventive way. The social aspects of sex offences will be also the subject of thorough inquiry.

Ontario made a beginning with the statute that took effect in July, 1918. A year's experience has justified it, but has revealed certain defects which should be removed. Conferences have been called by the Chairman of the Provincial Board of Health to consider means of strengthening the Act. Greater clinic facilities are required, and it should be less easy for victims of the disease to evade the compulsory provisions of the law and become a public menace. Ontario's share of the Federal grant will be \$57,000, and the late Government had intended to ask the legislature to duplicate it. No doubt the new Government will avail itself of the Federal offer and enable the Province to do its share in the fight against a dreadful scourge.

Reprinted from the *Toronto Globe*, November 17th, 1919.

Smallpox in Toronto

A widespread outbreak of smallpox occurred in Toronto early in November. The cases were mainly of a mild type. The rush of citizens to be vaccinated was so great that those responsible both for the production of smallpox vaccine virus and for the vaccinations had great difficulty in coping with the demand. A small but noisy minority in the city rushed into print to express the condemnation of the Health Department in organizing a campaign of vaccination. A member of the Board of Control is reported in the daily press to have declared that

he would refuse to pay his school taxes if his child was not permitted to attend school without a certificate of vaccination. This highly edifying spectacle of a member of one of the municipal governing bodies indicating his intention of defying the law should have but one result. All good citizens who are interested in the furtherance of the best interests of public health work in Toronto are advised to see to it that the controller regains his status as a private citizen on January first next.

The Canadian Red Cross Society

In the July number of the JOURNAL an editorial dealing with the question of "Financial Support of National Health Promoting Agencies," the desirability of the Canadian Red Cross Society taking steps which might lead to co-ordination of the activities of these agencies was emphasized.

The address of Sir David Henderson, Director General of the League of Red Cross Societies, Geneva, at a public meeting held in Toronto under the auspices of the Canadian Red Cross Society on November 20th, has again raised this question.

We would then simply quote from the editorial mentioned above as follows: "There are at present in Canada several national organizations which would qualify, if Dr. Hoffman's definition be accepted, as agencies which should receive such support. And what is almost equally important, some definite co-ordination of the activities of these associations might be attempted. Thoughtful people interested in public health and social service work would welcome some action on the part of the Canadian Red Cross Society looking to the calling of a conference of representatives of that Society, and the Canadian Public Health Association, the Canadian National Mental Hygiene Association, the Canadian National Council for Combating Venereal Diseases, the Canadian Association for the Prevention of Tuberculosis and the Canadian Association for the Prevention of Blindness; to the end that some measure of co-operation may be assured and possibly some provision made for the support of these various agencies".
